					Κ	ans				oard												f Nurs	sing	,				De	ntal	Во	ard						ard c			ard (
General Category	Description	Trai	iner	rac tic, Po	tnl. c Lic i en a	lic ro ne p an c d o	o-u rap tih	oat T nic e	c. Γh er. &	Physi Therap PT Assist Licens	ant ure/	ysi cia n MD	ar Assi n	n ista t	Po I st co Gr I ad.	dio s og ic o Te	sp. s Th 1 era e pis S	sp. Th er. Std	LN	RN PN MHT	F	ARNP/ RNA Advanc ed Practic	LP N AR NP	, LP N	nta I &H ygi	nta I &H ygi	nta I Hy gie	nta e I l Hy s gie L	st e ne l ia s .e l	st e ne s ia f	en se to Pra			st			metri		Reco BLS Verif	S Legogniti S & All ficati	tion ALS tion S
		Арр	Rn wl	Арр	App	Rn R	n vl A	рр А	pp A	PT App Rn wl	PTA Rn wl	App & Add	Арр	Rn wl	App A	Арр	Арр А	pp F	App Rn/ _pn	nd S	Srv y	pp Srv	Rei ns	Rn wl	Арр	Арр	App (Cha nge Spn	рр А	рр А	pp !	Rn R wl r	ei Rı ıs w	n Re I ns	App by Exa	Rec ip	Gla uco ma	Rn wl	Арр	Rn wl	Rei ns
	Date of Application	П								\neg		n				\neg	\neg	\neg			\neg		-					· ra						г			1	\Box			
Provider	Last name of provider																																								
Personal	First name of provider																																								
Information	Middle name of provider																																								
	Generational suffix of provider																												Т	Т				Т						\Box	
	Preferred title (Dr., Mr., Mrs. Ms, etc.)															T																						П			
	Maiden, previous or other name used																																								
	Date of birth of provider								\top							╅																									-
	Place of birth								\top							╅					т																	П	\neg	\neg	
	Social security number					_			T							\neg	\neg	T																	1						
	NPI Number								7							7					Т									T				Т				П	П	\neg	
	UPIN						T		Т							Т	\neg	\neg																							
	OETracker number																																								
	Active in the military?																																								
	U.S. Citizen?																																								
	Other citizenship status: qualified alien, foreign national, etc.																																								
	Ethnic origin of provider				\neg		_		Т							7	$\overline{}$	Т											1				\top	+				П		$\overline{}$	
	Provider's marital status															7		T											1				\top	+				П		\neg	
	Indicates gender																																								
Provider Non-	Address (street, city, state, zip)								T							T																						П			
Practice	Previous Address(es)	П			\neg	\top	Т		Т	\neg						\neg	\neg	Т			т						\neg			Т	Т	\top	\top	Т				П	\neg	\neg	\Box
Contact	Phone number																																								
Information	Cell Phone number	П							T				\Box		П	\neg	\neg	T			Т		П							T							П			\neg	
	Email address																																								
	Fax number	П					T		Т						П	╅	\neg	Т			T										T	Т	Т	Т				П	П	\neg	
	Name of county (or abbrv.)																																								
	Address of record (preferred adrss															T																								\Box	
Provider's	Name of office/practice/agency				\dashv	\top	\dashv	\dashv	\dashv		1					十	\neg	十	十	T	\dashv		1				寸	\dashv	十	\dashv	十	十	\top	\dagger	+	1	1		\dashv	十	ヿ
Work	Address (street, city, state, zip)							1	十							一	\neg	十	寸	\neg	\top		1				寸				一	十	\top	+	1				寸	一	\neg
(Practice/Office	Name of county (or abbrv.)	П			1	1		1	十							一	\neg	十	十	\neg	\top		1				寸	T			\neg	十	\top	T	1				寸	一	\dashv
/ Agency)	Phone number	П			7	T		T					П			寸	\neg										寸		丁		丁	十	\top								
	Fax number				7	T		T	一				П			寸		T			T						寸	\dashv	十	1	丁	十	\top	1					\Box		
	Cell Phone															一		寸									\neg		一									\Box	\neg	\Box	\Box

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General Category	Description	Train	ner r	Chi In rop tn rac Li tic, ei Po so	I. did c ind n an e d	ro- pra cti c	uro pat hic Do	c. Th er. &	Assist	ant ure/	ysi cia n MD	ar Assi nt	n sta t	st d Gr ld ad. i per 1	lio s og T ic e re p	p. sp Th Thera era ois Sto	o. n d	RN LPN LMH	Г	ARNP/ RNA Advand ed Practio	AR NP	LP N	I &H ygi	I &H ygi	I Hy gie	I Hy s gie I	he sia s Le	he sia Le F	to Pra						netris	R B V	EMS L Recogn BLS & /erifica of EM	nition ALS ation
		App	Rn wl	Арр Ар	Rn wl	Rn wl	Арр	Арр	App Rn wl	PTA Rn wl	App & Add	Арр	Rn wl	Арр А	pp A	.pp Apı	Ap Rr Lp	End rs	Srv y	App Srv	/ Rei	Rn wl	Арр	Арр	Арр	Cha nge Spn	.pp A	App A	pp	Rn Re wl ns	i Rn	Rei ns	App by Exa	Rec ip	Gla uco ma	Rn wl A	pp Rn wl	n Rei I ns
	Email address																																T					
	Type of Practice																																					
	Hours of Operation																																					
	Othr Prfsnals practicing at site																																					
Provider	Language(s) Spoken																																					
Provider DEA	DEA number assigned to provider																				Г																	
Provider	Highest education completed:																																					
Education	High school name																																				\Box	\Box
High School	High school address																																					
	High school Grad date or GED date																																					
Post-	Name of the educational institution																																					
Secondary/	(post-secondary and/or professional)																																					
Professional Training	Address of institution																																				Щ	
Training	Education Start Date																			oxdot																		
	Education End /Graduation Date																																					
	Name of internship/residency hospital or department, if applicable																																					
	Type of the degree/certificate (MD,					1							_													-										\dashv	+	+
	Internship details - Dates/ # of hours,															_										+	+			+	+	+				+	+	+
	names of supervisor/director of																																					
	Post-grad or post-doctoral sprvsn details - Dates/ # of hrs, sprvsr name																																					
	Accreditation of school/program																																					1
	Name of program director		T									T					1										1	T	T				1					\Box
	Type of Program - Rotating or		7									一															1	T	T									\top
Other Education	Any additional training/ education (med military, pub hlth, business,		T																																	十	1	\prod
	Name of school/institution	$\vdash \vdash$	-	+					\vdash	\vdash		\dashv	\dashv		+	\dashv										-+	+	\dashv	+	+	+	+				+	+	+
	Address of school/institution	$\vdash \vdash$	-	+					\vdash	\vdash		\dashv	\dashv		+	\dashv	+			\vdash	+					-	+	\dashv	+	+	+	+				+	+	+
	Type of additional/other training, degree/certificate (MD, DO, RN,		T																								1			\top								П

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General Category	Description	Athleti Traine	rac tic Po	c Lic ;, en o se	ine an d	pra cti c	pat hic Do	Th er. &	Assista Licensu	st & ant ure/	ysi cia n MD	an Assi: nt	sta	st di Gr lo ad. id per T	io s og T c e e p	p. sp h Th ra er is Ste	1	RN LPN LMH	г	ARNP/ RNA Advand ed Practio	AR NP	LP N	I &H ygi	I &H ygi	Hy H	I h Iy si ie L	e h ia s e L	e s ia t .e P	e o ra						metri	ist	EMS Reco BLS Verif of	S Legogniti S & Al ficati	gal ion LS ion
		App R	n /l Ap	рАрр	Rn wl	Rn wl	Арр	Арр	App Rn wl	PTA Rn wl	App & Add	Арр	Rn wl	App A _l	pp A _l	рр Ар	Ap Rn Lp	P End rs	Srv y	App Srv	Rei ns	Rn wl	Арр	Арр	App S	ha ge pn Al	ор А	ррА	pp	Rn Re wl ns	i Rn	Re	i by Exa	Rec	Gla uco ma	Rn wl	Арр	Rn wl	Rei ns
	Name of specialty Area of emphasis (clinical psych, school psych, etc.) Applicant name on degree/transcript										n			#	#											ra		1		1	$ar{\perp}$			F				$\frac{1}{4}$	
	Information specific to professional exams and/or graduate hours for																																					$\frac{1}{2}$	
	If not BOC certified, provide date are scheduled to sit for exam Other information related to		-										4	_			1													-	\downarrow	-	╘	L	<u> </u>			\dashv	
Practicum	Did you, as part of degree requirements, complete a practicum?			Ι																													Γ						
	Agency name where practicum was Agency/college address			_										\pm			+														上	1	\perp	\perp	上			$\frac{1}{2}$	
	Sponsoring college/university Beg & End Dates of practicum Hours worked per week		+	+								+	4	+	+	+	F				_				\dashv	+					十	F	+	+	\pm	H	\Box	\dashv	
	Total practicum hours completed Onsite practicum supervisors names				Н									+												+			+		Ŧ	+	Ŧ	au	\vdash	H	\dashv	\dashv	
	Supervisor(s) Address(es) # of hrs were in direct client contact													+			+														+	+	+	<u> </u>	 	H		#	=
	Describe responsibilities in practicum													\pm																	上		ightharpoonup	igspace	士			\Rightarrow	
	Coordinator Preceptor, preceptor number Date completed			+										+	+											+					十		十	\vdash	‡	H	H	\dashv	
Continuing Education	Number of continuing educations hours in a specified period? (e.g.,																																						
Provider Certification/ Specialty	Name of Specialty Name of specialty													\pm							L										上		\pm	L	上		H	<u></u>	
	Name of subspecialty Indicates type of specialty (prim, sec,			Ė							\exists	\Rightarrow	\downarrow	\pm	\pm										\dashv	1			_		士		\pm	上	\pm	\exists	\Box	\Rightarrow	
1	Member of specialty association?				Ш							ļ				ļ					1										丄	ļ	丄	丄	Щ	Ш	$oldsymbol{\sqcup}$	\perp	

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General Category	Description		rac tic Po	Lic , en se	ine an d	pra cti c	pat hic Do	Th er. &	Assista Licensu	nt re/	cia n MD	Assi: nt	sta	Gr lo ad. id per T	g T c er e pi	h Th ra er. is Sto	1	RN LPN LMH1		ARNP/ RNA Advand ed Practio	AR NP	N	&H ygi	&H ygi	Hy gie	Hy gie	sia Le	sia Le	to Pra							etrist	Red BL Ve	MS Lecogni LS & A erifica of EM	ition ALS ition
		App Ri	n Ap	Арр	Rn wl	Rn wl	Арр	Арр	App Rn wl	PTA Rn wl	App & Add	Арр	Rn wl	App Ap	op Ar	ор Арр	App Rn/ Lpn	End rs	Srv y	App Sr	Rei ns	Rn wl	Арр	Арр	Арр	Cha nge Spn	Арр	Арр	Арр	Rn wl	Rei I	Rn I	Rei I	pp by R	Rec u	la co R na W	n Apr	p Rn wl	Rei ns
	Submitting application for endorsement?									T																era				П	T	T	T			30	T	Т	П
Provider Certification/ License	Name of credential (License, Certification, Registration) for this application (or renewal, etc.)																																						
	Status of credential (? Current, active, inactive, expired, renewal etc.)																																						
	Offer an option to NOT renew																																						
	Certification/License Number																																						
	Certification Level or License suffix																																						
	Obtained re-licensure hours																																						
	Initial License Date																																						
	Kansas License Date																																						
	Expiration date of certification																																						
	Name under which license is to be/was issued?			Г																																			
	Seeking temporary permit?			1																										H	十	十	\neg			工	\top	+	
	Ever previously filed app for lic in KS?														Т			П			Г											\Box							
	Other Professional license/certificate or temporary permit (P=Previously,		f	Г											ı															П			T					+	
	a. State/territory													\neg	\top															П		7						1	
	b. Issuing body			Т	П					П				т	Т	Т															\neg	T	T	T		Т		1	
	c. Under what name?																															T						1	
	d. license number																															T						1	
	e. type of license/certificate																															T						1	
	f. effective date/year issued or date of applic.																													П									
	g. Date of most recent renewal			т	П					T				\neg	Т	Т															\neg	T	\neg			\top		1	
	h. current status																														一	寸				\top	1	1	
	i. Expiration date																														丁								
	j. original state of licensure?																																						
	k. If not continuous, what was non-licensed period?																																						

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General Category	Description		1	rac Lic tic, en Po se	ine an d	pra cti c	pat hic Do	Th er. &	Assist	ant ure/	cia n MD	Assi nt	n sta t	Po R st d Gr lo ad. i per T	io sp og Ti c er e pi	o. sp. h Th a er. s Std	 	RN LPN LMHT		ARNP/ RNA Advanc ed Practic	AR NP	N	&H ygi	&H ygi	Hy gie	Hy s gie L	ia s .e I	sia 1 Le F	ra				0	pton	netris	st E Re B V	MS Lecogr BLS & erification	egal nition ALS ation VIS
		App R	Rn wl	Арр Арр	Rn wl	Rn wl	Арр	Арр	App Rn wl	PTA Rn wl	App & Add	Арр	Rn wl	App A	рр Ар	рр Арр	App Rn/ Lpn	End rs	Srv y	App Srv	Rei ns	Rn wl	Арр	Арр	App	Cha nge Spn	рр А	ърр А	pp	Rn Re wl ns	i Rn wl	Rei ns	App by Exa	Rec ip	Gla uco ma	Rn wl A	pp Rn wl	Rei ns
	I: other details										'n															era	_					_	m		Ann			\top
	Providing volunteer or charitable health services?																														Г							
	Why was license allowed to expire?																																					
	Since license expired, have youin Kansas?																																					
Privilege	Name of Hospital affiliation																																					
	Employer name																																					
History/Status	Employer's address																																					
	Start Date																																					
	Ending Date																																					
	Position Title																																					
	Reason for Termination																																					
	Contact name																																					
	Contact Phone Number																																					
	Other work history details																																					
	Current Employment Status (working in prfsn, retired, not working, working																																					
Status	Currently practicing in advanced																																					
Simplify by combining with	Describe practice setting and professional responsibilities.																																					
above section?	Were any hours worked in Kansas?																																					
	Hrs/wk in direct patient care in KS																																					
	Of the above - hours in Administration/ research/teaching																	П																				
	Working in nursing or mental health technician services in Kansas?																	П																				
•	Specific information about current/recent employment																																					
	a: name of agency(ies)																								\neg													
	b: name of associated physician														T		ĺ											T	Т		\Box		1			\Box		

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General Category	Description		ner re ra ti	op ti ac L ic, e	nl. di	c ro- e pra cti c	uro pat hic Do	c. Th er.	Thera P Assis Licen	T stant sure/	ysi cia n MD	Assi n	n ista t	St d Gr ld ad.	lio s og 1 ic e Te p	Re Resp. sp. Th Thera er. Sto	i i d	RN LPN LMH	Г	Pract	nc N Al tic N	I LI R N P	P I &H ygi	I &H i ygi	I Hy gie	I Hy gie	he sia Le	he sia Le	se to Pra			yger st			metri	R E V	EMS L Recogr BLS & /erifica of EM	nition ALS ation MS
		App [Rn wl	ърр А	pp Ri	n Rn I wl	Арр	Арр	App R	T PTA n Rn d wl	App & Add	Арр	Rn wl	Арр А	ърр А	рр Ар	App Rn. Lpr	End rs	Srv y	App	Srv Ro	ei R s w	App	Арр	Арр	Cha nge Spn	Арр	Арр	Арр	Rn wl	Rei R	n Re	App by Exa	Rec ip	Gla uco ma	Rn wl	pp Rn	Rei ns
	c: address of site(s)	П		1		-				\top	n	П		\neg	1	\top										Sra.									Ann		\top	\top
	d: county																								1													
	e: phone number of site(s)																								1													
	f: type of work setting																								1													
	g: hours/week																																					
	h: % of hours																								1													
	i: average # of patients seen per													\neg																丌	一						\top	
	j: weeks/year		T								1																										\top	1
	k: BSRB License required?									+														1		H				\neg	一		1				\top	+
	I: working w/o supervision?																																					
	m: in a clinical supervisory training plan?																																					
	n: conducting psychotherapy																																					
	o: working under supervision?																																					
	p: supervisor's name/license type &																																			i		
	q: other work details		<u> </u>		+									_							\top			1		Н							+				+	+
	Length of employment									-																		ヿ		\neg	-	1					+	+
	Been continuously employeed?		T								1																			\neg							\top	+
Supervisory Role	Do you supervise: P A, Athletic Trainer, Rad. Techn., Phys. Ther																																					
Provider Sponsorship	Sponsoring Professional Name, Address, Phone, License #,				Г																										+							
Provider	Desciption of ability to safely practice																			\dashv	\dashv				Г												\top	+
Medical Condition	Used alcohol/drugs/ etc which may cause addiction/dependence, to		1		Т					Т					T								Г							Т	Т	Т						
	Used controlled substances w/o valid presciption?		T												T															\Box	1							
	Ever engaged in your practice while any phys. /ment. disability, loss of motor skill or use of drugs or alcohol,														Ī																\dagger							
	Any physical/mental problems or disabilities which could affect ability to competently practice your profession?																																					

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General Category	Description	Athlet Train	er re ra ti F	op tr ac L ic, e	nl. di ic in n ar e d	ro- pra cti c	uro pat hic Do	c. Th er. &	Thera Ass Lice	apist & PT istant nsure	Sysicia cia n / MD	Ass r	n ista it	Po st Gr ad. per	dio log ic Te	sp. s Th Tera e pis S	p. Th er. std	RI LP LM	N HT	P	ractic	N AR NP	LP N	I &H ygi	l &H∣ ygi g	I Hy H gie g	l he ly sia ie Le	he a sia e Le	se se a to Pra	a					ptom		R E V	ecog BLS & erific of E	
		App R	Rn wl	pp A	op Ri	n Rn	Арр	Арр	Арр	PT PT Rn Ri wl w	A Apr & A Ado	App	Rn wl	App	Арр	Арр А	pp R L	ipp Rn/ pn	nd Si	rv y Aj	pp Srv y	Rei ns	Rn wl	Арр	App A	opp no	ha ge on	рАр	рАр	Rn wl	Rei ns	Rn wl	Rei ns	App by Exa	Rec ip	Gla uco ma	Rn wl A	pp R	n Rei I ns
Insurance	Professional Liability Ins Info		\top	Т			Г	Г	П		1			П	\neg	\top	T			Т	Т				П	-		Т	Т				Г	m		^^^		Т	\top
Liab. Action	Ever sued for malpractice?																	+																					+
Provider	Ever arrested?													П		\neg														Т	т						一		1
Criminal / Disciplinary	Ever convicted of a misdemeanor?			T												Т																							
Action	Ever convicted of a felony? Or																																						
	Any criminal proceedings pending (fed or state)?																																						
	Ever court martialed or dishonorably discharged?																																						
	Any investigation and/or discip. action (past or pending) against any license,certification,or registration?				I					I																													
	License, certif. or reg. ever denied, revoked, suspended or other disciplinary action taken?																T																						
	Complaint ever filed with a prfsnal assoc or certifying/licensing body?																																				$oxed{oxed}$		
	Ever had allegations of sexual abuse																																						
	Licence/certification ever																																						
	Has employment been terminated/ suspended for misfeasance,																																						
	Ever been found guilty of or liable for fraud or deceit in connection with																															1							
Public Trust	Been rejected for membership in a professional organization, had membership revoked, been censured																																						
	Ever aided or abetted a person, not a licensed soc. wrkr, in representing him/her as a licensed social worker?																																						
	Ever been dropped, suspended, expelled, fined, place on probation,																																				$\underline{\perp}$		

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General Category	Description	Athlet Traine	ier r	op tnac Litic, e	il. did ic ine n an e d	ro- pra cti c	uro pat hic Do	c. Th er. &	Physi Therap PT Assist Licens	ist & ant ure/	ysi cia n MD	as Ass n	n ista t	Gr ad.	dio s log i ic e	sp. s Th Tera e	p. Γh er. etd	RN LPI LMF	N IT	Ad	RNP/ RNA Ivanc ed actic	N AR NP	LP N	l &H ygi	l &H ygi	I Hy gie	l Hy s gie	he sia s Le	he sia Le F	se to Pra						ometr		Rece BLS Veri	is Lecognites & Arificates of EMS	tion LS tion S
		App R	Rn wl	App Ap	op Rn wl	Rn wl	Арр	Арр	App Rn	PTA Rn wl	App & Add	Арр	Rn wl	Арр	App A	Арр А	pp F	Rn/ End rs	d Sr	App	p Srv y	Rei ns	Rn wl	Арр	Арр	App	Cha nge Spn	App A	Арр А	.pp	Rn I wl	Rei R	n R	ei by S Ex	p , Re a ip	Gla uco ma	Rn wl	Арр	Rn wl	Rei ns
	Been warned,censured, had admissions monitored or limited or		٦																								S.F.A.									And		П	П	
	Ever denied staff membership with a health facility?																																							
	Been requested to resign withdraw or terminate your position with a partnership,prof assn, or practice		ı																																					
	Have you been denied a DEA or ST. narcotics/controlled substances reg. certifi., had it revoked, suspended, restricted in any way, or warned by such agency?																																							
	Ever denied provider participation in any medicaid or medicare programs?		ı																																					
	Have you terminated, sanctioned penalized or had to repay money to any medicaid or medicare program.																																							
MISC	Are you currently registered by BSRB as the unlicensed assistant of a licensed KS psychologist?				Ī																																			
	Do you provide EMS services to your community and/or business/industry?																																							
	If yes to above, with what type of service as your involved?																																							
	If provide services to community and/or busnss/industry, who operates it?:not affiliated, fire																																							
	Current EMS involvement is:full time, part time,volunteer																																							
	Indicate method of compensation (EMS): No pay,call time,per call,hourly rate,salary.																																							

						Kai	nsa	s Si	tate	Bo	ard o	f He	eali	ng A	Arts						Boa	rd c	of N	ursi	ng					De	enta	al Bo	oar	ď						ard nine	of ers			d of gen	
General Category	Description		letic iner	rop rac tic,		dic ine an	ro- pra cti	uro pa i hio	o c it T c ei	. TI h r. /	Physic nerapis PT Assista icensu	et &	ysi cia n	а	n ista it	st	dio log ic	sp. Th era	sp. Th er.		RN LPN .MH1		RN Adva ed	A I	LP N AR	, LP N	nta I &H	De nta I &H ygi	nta l I Hy	nta I Hy	est he sia	est he sia	en se to		tist		geni st	C	Opto	metr	ist	Red BL Ve		nition ALS ation	
		Арр	Rn wl	Арр	App	Rn wl	Rn wl	Apı	p Ar	op Ar	PT Rn wl	PTA Rn wl	App & Add	Арр	Rn wl	Арр	Арр	Арр	Арр	App Rn/ Lpn	End rs	Srv y	Арр	Srv I	Rei ns	Rn wl	Арр	App	App [Cha nge Spn	Арр	Арр	Арр	Rn wl	Rei ns	Rn wl	Rei ns	App by Exa	Rec ip	Gla	, Rn wl	App	p Rn	Rei ns	
COURSE INFORMATION	Sponsoring organization, organization number/name, course number course level category date. Course taken with Education Incentive Grand Funding? Y/N Ever identified yourself as a social																														-												E		
Emerg. System for Advance	worker in Kansas(excluding student work)? Willing to be included on registry of potential volunteers during an								<u> </u>																_												_				L	L	$\frac{1}{1}$		
Reg. of Professional Organizations	emergency? Check one or more Membership in Prof.organization?																														\exists										L	L	$\frac{1}{2}$		
O gamzanons	Participation in Professional org. meetings? Willing to serve on medical/dental malpractice screening panel?																								1						$\frac{1}{2}$	\dashv					_						-		
	ECFMG (<u>C</u> ertificate #, <u>I</u> ssue Date, <u>E</u> xp Date																																												

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General Category	Description	Lice ure Prac e c Psyc	ctic of	LM LP	LB SW or LM SW	CS W	LP C	LP C LC PC	PC	LM FT	MF T	LC P	(Othe Ab Cour	r Dru use nselo stratio	or	LP, LC P, LC PC,	LC P,	W, LM	LM FT, LC MF T	P, LC	Ad	Adm	Care iinist icen	trato		la pa	tho or	age logy	L	Dietiti Licen		Aid Ho	le or ome alth	Me dic ati on Aid	ar ma cis	ar ma cy	ar ma cy
		Арр	Rec ip	Арр	Арр	Арр	Арр	Rei ns	Арр	Арр	Арр	Арр	Арр	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	Арр	Rn wl	Rec ip	Te mp	Rei ns	Арр	Rn wl	Re ns	Арі	Rn wl	Rei ns	App	Intr St. App	Арр	Арр	Арр	App
	Date of Application	П																						г					г	т						Г		г
Provider	Last name of provider																																					
Personal	First name of provider																												T									
Information	Middle name of provider																																					
	Generational suffix of provider	П		П								П																	Т			\Box	Т			Г		Т
	Preferred title (Dr., Mr., Mrs. Ms, etc.)																												1	Т	1		1			Г	T	1
	Maiden, previous or other name used																																					
	Date of birth of provider			\blacksquare																									Т			Т						
	Place of birth	П		П								П																	T	т	1		\top					
	Social security number																																					
	NPI Number	П		П								П																		т	1	\top	Т		П	Г	П	Т
	UPIN																															1	1					
	OETracker number																																					
	Active in the military?												1																	1		1						
	U.S. Citizen?																																					
	Other citizenship status: qualified alien, foreign national, etc.																																					
	Ethnic origin of provider																																					
	Provider's marital status																													T	1							
	Indicates gender																													T								
Provider Non-	Address (street, city, state, zip)																																					
Practice	Previous Address(es)																																					
Contact Information	Phone number																																					
mormation	Cell Phone number																																					
	Email address	П																																				
	Fax number																																					
	Name of county (or abbrv.)																													Т	1	1						
	Address of record (preferred adrss																													Т	1	T						
Provider's	Name of office/practice/agency																											T	1	T	1				П	Г		Г
Work	Address (street, city, state, zip)																											1		T	1	T			П	Г		
(Practice/Office	Name of county (or abbrv.)																											1		\top	T	T			П	Г		П
/ Agency)	Phone number																																			Г		
	Fax number																													Г								
	Cell Phone																													T		T						

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General Category	Description	Lice ure Prac e c Psyc	for ctic of		SW or	CS W		LP C LC PC		LM FT	LC MF T	LC P		Othe Ab Cour	r Dru use nselo tratio	r	LP, LC P, LC PC,	P,	LM	LM FT, LC MF T	LC P, LC PC,	Ac	Adm	Care inist cens	rato		la pa	peed ngual thol or idiol	age logy		Dietit Licer		Aid He	de or ome ealth	Me dic ati on Aid	ar ma cis	ar ma cy	ar ma cy
		Арр	Rec ip	Арр	Арр	Арр	Арр	Rei ns	Арр	Арр	App	App	Арр	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	Арр	Rn wl	Rec ip	Te mp	Rei ns	App	Rn wl	Re	ei Ar	op Rn wl	Re ns		Intr St. App	Арр	Арр	Арр	Арр
	Email address Type of Practice Hours of Operation Othr Prfsnals practicing at site																														\mp							
Provider	Language(s) Spoken												t		г														t		+	\dagger	+	1	+	1	 	
Provider DEA	DEA number assigned to provider																																					
Provider Education High School	Highest education completed: High school name High school address High school Grad date or GED date																														+							
Post- Secondary/ Professional Training	Name of the educational institution (post-secondary and/or professional) Address of institution Education Start Date Education End /Graduation Date Name of internship/residency hospital or department, if applicable																																					
	Type of the degree/certificate (MD, Internship details - Dates/ # of hours, names of supervisor/director of Post-grad or post-doctoral sprvsn details - Dates/ # of hrs, sprvsr name																														+	+	+					
-	Accreditation of school/program Name of program director Type of Program - Rotating or																														#							
Other Education	Any additional training/ education (med military, pub hlth, business, Name of school/institution Address of school/institution Type of additional/other training,																														+	<u> </u>	<u>_</u>		<u></u>			
	degree/certificate (MD, DO, RN,																														\perp	\perp	\perp			L	$oxed{oxed}$	

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General Category	Description	Lice ure Prac e c Psyc	ctic of	LM LP	LB SW or LM SW	CS W	LP C	LP C LC PC	PC	LM FT	LC MF T	LC P		Icoh Other Abi Coun egist	r Dru use iselo	nd Ig or on	LP, LC P, LC PC,	LM LP, LC P,	LS CS W, LM SW	LM FT, LC MF T	LC P, LC PC,	Ad	Adm	Care inist icens	rato		la pa	peed ngua thole or idiole	age ogy		Dietit Licen		Aid Ho He	e or ome alth	dic ati on	ar ma cis	ar ma cy	ar ma cy
		Арр	Rec ip	Арр	Арр	Арр	Арр	Rei ns	Арр	Арр	Арр	Арр	Арр	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	Арр	Rn wl	Rec ip	Te mp	Rei ns	Арр	Rn wl	Rei ns	Ap	Rn wl	Rei ns	Арр	Intr St. App	Арр	Арр	Арр	Apr
	Name of specialty																													1				- 44		\dashv	Г	\vdash
	Area of emphasis (clinical psych, school psych, etc.)																																					
	Applicant name on degree/transcript																																					Ì
	Information specific to professional exams and/or graduate hours for																																					
	If not BOC certified, provide date are scheduled to sit for exam	П		П																											Т					П		
	Other information related to																												t	1	1					\exists		H
Practicum	Did you, as part of degree requirements, complete a practicum?																															Γ						
	Agency name where practicum was						\vdash				┢		_				\vdash												t	T	1					\dashv	一	
	Agency/college address												Н																							\dashv	\vdash	一
	Sponsoring college/university																																			\dashv	\vdash	┢
	Beg & End Dates of practicum																												T	Т	1					\neg		t
	Hours worked per week												г																	T								T
	Total practicum hours completed																																					1
	Onsite practicum supervisors names																																					
	Supervisor(s) Address(es)			П																										Г								
	# of hrs were in direct client contact																																					
	Describe responsibilities in practicum																																					
	Coordinator																																					1
	Preceptor, preceptor number																																					
	Date completed																																					
Continuing Education	Number of continuing educations hours in a specified period? (e.g.,																												Г									
Provider	Name of Specialty Board																												П	Т	Т					\Box		1
Certification/	Name of specialty										T						Т												t	T	1	t				\dashv	Т	T
Specialty	Name of subspecialty										T																		T	T	1	1	t	П		\dashv		
	Indicates type of specialty (prim, sec,																												T	T		1				\Box		
	Member of specialty association?	H						1			H						\vdash			I								1	t	t	+	1	1	\vdash		\dashv	\vdash	一

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General Category	Description	Lice ure f Prac e o Psyc	tic of		LB SW or LM SW	CS W	LP C	LP C LC PC	LC PC	LM FT	MF T	LC P	:	Alcoh Other Abu Coun Regist	Dru use iselo	nd g or on	LP, LC P, LC,	LM LP, LC P,	LS CS W, LM SW	LM FT, LC MF T	LC P, LC PC,	A	Adm	Care inist icens	rato		la pa	ingu atho	ech- lage logy r logy	, L	Dietiti Licen		Aid Ho	de or ome ealth	Me dic ati on Aid	ar ma cis	ar ma cy	r ar a ma
		App	Rec ip	Арр	Арр	Арр	Арр	Rei ns	Арр	Арр	App	App	Ap	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	Арр	Rn wl	Rec ip	Te mp	Rei ns	App	Ri	n Re	i Ap	Rn wl	Re ^s	App	Intr St. App	Арр	Apr	Ар	р Ар
	Submitting application for endorsement?	П									Г	Γ																	T	T	Т	Г	Т		Т	Г	Г	T
Provider Certification/ License	Name of credential (License, Certification, Registration) for this application (or renewal, etc.)																																					
	Status of credential (? Current, active, inactive, expired, renewal etc.)																																					
	Offer an option to NOT renew																																	1	1	T	T	†
	Certification/License Number																																				T	
	Certification Level or License suffix																																					
	Obtained re-licensure hours																															1	1				T	
	Initial License Date																																					
	Kansas License Date																																					
	Expiration date of certification																																					
	Name under which license is to be/was issued?																																					
	Seeking temporary permit?																																				T	
	Ever previously filed app for lic in KS?																																					
	Other Professional license/certificate or temporary permit (P=Previously,																																					
	a. State/territory																																					
	b. Issuing body																																					
	c. Under what name?																																					
	d. license number																																				┸	
	e. type of license/certificate																								$ldsymbol{ldsymbol{ldsymbol{eta}}}$		L		\perp	丄	丄	丄	丄	$oldsymbol{\perp}$	\perp	上	丄	丄
	f. effective date/year issued or date of applic.																																				$oldsymbol{\perp}$	\perp
	g. Date of most recent renewal			$ \bot \!\!\! \downarrow$							$oxed{oxed}$	_																\perp	\perp	丰	丄	丄	\perp	丄	丄	丄	丄	丄
	h. current status										$oxed{oxed}$																		\perp		4		4	lacksquare	丄	丄	丄	丄
	i. Expiration date	ш									$oxed{oxed}$	_																	\perp		4		4		4	丄	丄	丄
	j. original state of licensure?	Щ									$oxed{oxed}$																		\perp		4		4	丄	丄	丄	丄	丄
	k. If not continuous, what was non-licensed period?																																					

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General Category	Description	Lice ure t Prace e o Psyc	ctic of	l li	or	CS W	С	LP C LC PC		LN FT	I MI	F LC		Alcoh Other Ab Cour Regis	r Dru use iselo	or	LP, LC P, LC PC,	ΙP,	LM	LM FT, LC MF T	LC	Ac	lult (Admi Li		rato		la pa	ngua ngua ithol or idiol	age ogy		ietitia icens		Aid Ho Hea	e or me alth	dic ati on	ar ma cis	Ph ar ma cy Te	ar ma cy
		App	Rec ip	App A	Арр	Арр	Арр	Rei ns	App	Арі	Ар	рАр	рАр	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	Арр	Rn wl	Rec ip	Te mp	Rei ns	Арр	Rn wl	Rei ns	Арр	Rn wl	Rei ns	Арр	Intr St. App	Арр	Арр	Арр	Арр
	l: other details	П		П								1	+																	П	Г					\sqcap	\Box	
	Providing volunteer or charitable health services?																																					
	Why was license allowed to expire?												Ī																									
	Since license expired, have youin Kansas?																																					
Provider Hosp. Privilege	Name of Hospital affiliation																																					
Provider Work	Employer name																																					
History/Status	Employer's address																																				Ш	
	Start Date																																					
	Ending Date																																					
	Position Title																																					
	Reason for Termination																																					
	Contact name																																					
	Contact Phone Number																																					
	Other work history details																																					
Current /Recent	Current Employment Status (working in prfsn, retired, not working, working																																					
Employment Status	Currently practicing in advanced																																					
Simplify by combining with	Describe practice setting and professional responsibilities.																														L							
above section?	Were any hours worked in Kansas?																																					
	Hrs/wk in direct patient care in KS																																			\square	Ш	
	Of the above - hours in Administration/ research/teaching																																					ĵ.
	Working in nursing or mental health technician services in Kansas?																																					-
	Specific information about current/recent employment																																					
	a: name of agency(ies)																																					
	b: name of associated physician																																				П	

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																																					arm	
General Category	Description	ure	for ctic of		sw	cs w		LP C LC PC		LM FT	MF T	LC P	0	Icoh Other Abi Coun egist	Dru use Iselo	r	Ρ,	LC P,	W, LM	LM FT, LC MF	P, LC		Adm	Care inist icens	rato		la pa	ngua thol or idiol	age logy	,	Dietit Licer		Aid Ho	le or ome alth	Me dic ati on Aid	ar ma cis	ar ma cy	ar ma cy
		Арр	Rec ip	Арр	Арр	Арр	Арр	Rei ns	Арр	Арр	Арр	Арр	Арр	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	Арр	Rn wl	Rec ip	Te mp	Rei ns	Арр	Rn wl	Re	ei S Ap	op Rn wl	Re	App	Intr St. App	Арр	Арр	Арр	Арр
	c: address of site(s)																												Т	Т	\top	Т			П	\Box		
	d: county																																			\Box		
	e: phone number of site(s)																																			\Box		
	f: type of work setting																																					
	g: hours/week																																					
	h: % of hours																																					
	i: average # of patients seen per																																					
	j: weeks/year																																			П		
	k: BSRB License required?																																			\Box		
	I: working w/o supervision?																																			П		
	m: in a clinical supervisory training plan?																																					
	n: conducting psychotherapy																																			\Box		
	o: working under supervision?																																					
	p: supervisor's name/license type &																																					
	q: other work details																												+	+	+	+			т	\vdash		\Box
	Length of employment																												╁	+	+	+			т	\vdash		\Box
	Been continuously employeed?																												╁	\top	+				т	\square	Г	\Box
Supervisory Role	Do you supervise: P A, Athletic Trainer, Rad. Techn., Phys. Ther																	Г												Ť								
Provider Sponsorship	Sponsoring Professional Name, Address, Phone, License #,																													t								
Provider	Desciption of ability to safely practice	\Box																Т											T	\top	+				т	П		\Box
Medical Condition	Used alcohol/drugs/ etc which may cause addiction/dependence, to																														1							
	Used controlled substances w/o valid presciption?																													T								
	Ever engaged in your practice while any phys. /ment. disability, loss of motor skill or use of drugs or alcohol,																																					
	Any physical/mental problems or disabilities which could affect ability to competently practice your profession?																																					

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General Category	Description	Pra e	ens for ctic of cho		LB SW or LM SW	CS W	С	LP C LC PC		LM FT	MF T	LC P		Other Abu Coun	Dru use selo	r	Ρ,	LC P,	W, LM	LM FT, LC MF	P, LC		Adm	Care inist icens	rato		la: pa	peed ngua thole or diole	ige ogy		ietiti: icen:		Aide Ho Hea	e or me alth	dic ati on	ar ma cis	Ph ar ma cy Te	ar ma cy
		Арр	Rec ip	Арр	Арр	Арр	Арр	Rei ns	Арр	Арр	App	App	Арр	Rn wl	Rei ns	Rec ip	Rn wl	Rei ns	Rei ns	Rei ns	Rec ip	Арр	Rn wl	Rec ip	Te mp	Rei ns	Арр	Rn wl	Rei ns	Арр	Rn wl	Rei ns	Арр	Intr St. App	Арр	Арр	Арр	Арр
Insurance	Professional Liability Ins Info																																			\Box	П	П
Liab. Action	Ever sued for malpractice?																																			\neg	П	Г
Provider	Ever arrested?																																					
Criminal / Disciplinary	Ever convicted of a misdemeanor?											Г																										
Action	Ever convicted of a felony? Or										Т																											Г
	Any criminal proceedings pending (fed or state)?									Г	Г		Г																									
	Ever court martialed or dishonorably discharged?																																					
	Any investigation and/or discip. action (past or pending) against any license,certification,or registration?																																					
	License, certif. or reg. ever denied, revoked, suspended or other disciplinary action taken?																																					
	Complaint ever filed with a prfsnal assoc or certifying/licensing body?																																					
	Ever had allegations of sexual abuse																																				Ш	L_'
	Licence/certification ever																																					<u> </u>
	Has employment been terminated/ suspended for misfeasance,																																					
	Ever been found guilty of or liable for fraud or deceit in connection with																																					
Public Trust	Been rejected for membership in a professional organization, had membership revoked, been censured																																					
	Ever aided or abetted a person, not a licensed soc. wrkr, in representing him/her as a licensed social worker?																																					
	Ever been dropped, suspended, expelled, fined, place on probation,																																					

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General Category	Description	Lice ure Pra e Psy	for ctic of		sw	LS CS W			PC		M MI		c	Oth Co	ner D Abus unse	e	L	P, I	LC P,	W, LM	LM FT, LC MF T	P, LC		Admi	Care inist cens	rato		la pa	pee ngu ithol or idiol	age logy	,	Dieti Lice		A H	lurse ide d lome lealtl Aide	or di e at h o	ic a ti m	ar a na n is c	ar ma ı cy	ar ma cy
		Арр	Rec ip	Арр	Арр	Арр	Арр	Rei ns	App	Ар	рАр	pAp	рА	pp F	Rn R	Rei R	ec F	Rn I	Rei ns	Rei ns	Rei ns	Rec ip	Арр	Rn wl	Rec ip	Te mp	Rei ns	Арр	Rn wl	Re	ei Al	op R	n R I n	ei Is	op S Ar	t. Ap	ab At	ррА	ιpp /	۱pp
	Been warned,censured, had admissions monitored or limited or											T	T	T			T	T	Т											Γ	Τ		T				Т	Τ	Т	
	Ever denied staff membership with a health facility?																																					Ī		
	Been requested to resign withdraw or terminate your position with a partnership,prof assn, or practice																																							
	Have you been denied a DEA or ST. narcotics/controlled substances reg. certifi., had it revoked, suspended, restricted in any way, or warned by such agency?																																							
	Ever denied provider participation in any medicaid or medicare programs?																																							
	Have you terminated, sanctioned penalized or had to repay money to any medicaid or medicare program.																																							
MISC	Are you currently registered by BSRB as the unlicensed assistant of a licensed KS psychologist?																																				\dagger	\dagger	1	
	Do you provide EMS services to your community and/or business/industry?																																							
	If yes to above, with what type of service as your involved?																																							
	If provide services to community and/or busnss/industry, who operates it?:not affiliated, fire																																							
	Current EMS involvement is:full time, part time,volunteer																	\downarrow	\perp												\perp						\perp	\downarrow	\bot	
	Indicate method of compensation (EMS): No pay,call time,per call,hourly rate,salary.																																							

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General Category	Description	ure	for ctic of		sw	LS CS W						LC		Alcoho Other Abu Coun Regist	Dru Ise selo	g r	LC P,	LP, LC P,	CS W, LM	LM FT, LC MF T	LC P, LC	4	Adm	Care inist icens	rato		lai pa	or			ietiti icen		Aide Ho	e or me alth	dic ati on	ar ma cis	Ph ar ma cy Te	ar ma cy
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COURSE INFORMATION	Sponsoring organization, organization number/name, course number course level category date. Course taken with Education Incentive Grand Funding? Y/N Ever identified yourself as a social worker in Kansas(excluding student work)?																																					
for Advance Reg. of Professional	Willing to be included on registry of potential volunteers during an emergency? Check one or more Membership in Prof.organization?																																					
Organizations	Participation in Professional org. meetings? Willing to serve on medical/dental malpractice screening panel? ECFMG (Certificate #, Issue Date, Exp Date																																					